EPISCOPAL CHURCH MEDICAL TRUST

Annual Enrollment 2024 Guide

Planning Your Journey

CHURCH PENSION GROUP
Passionate About Our Purpose

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Your Guide to Annual Enrollment

The Episcopal Church Medical Trust (Medical Trust) benefits are part of the journey to your overall well-being, ensuring that you have access to quality care. Use this guide to learn about the types of Medical Trust benefits available to you, key considerations when making your choices, and how to enroll. You can find additional resources and benefit details on *cpg.org*.

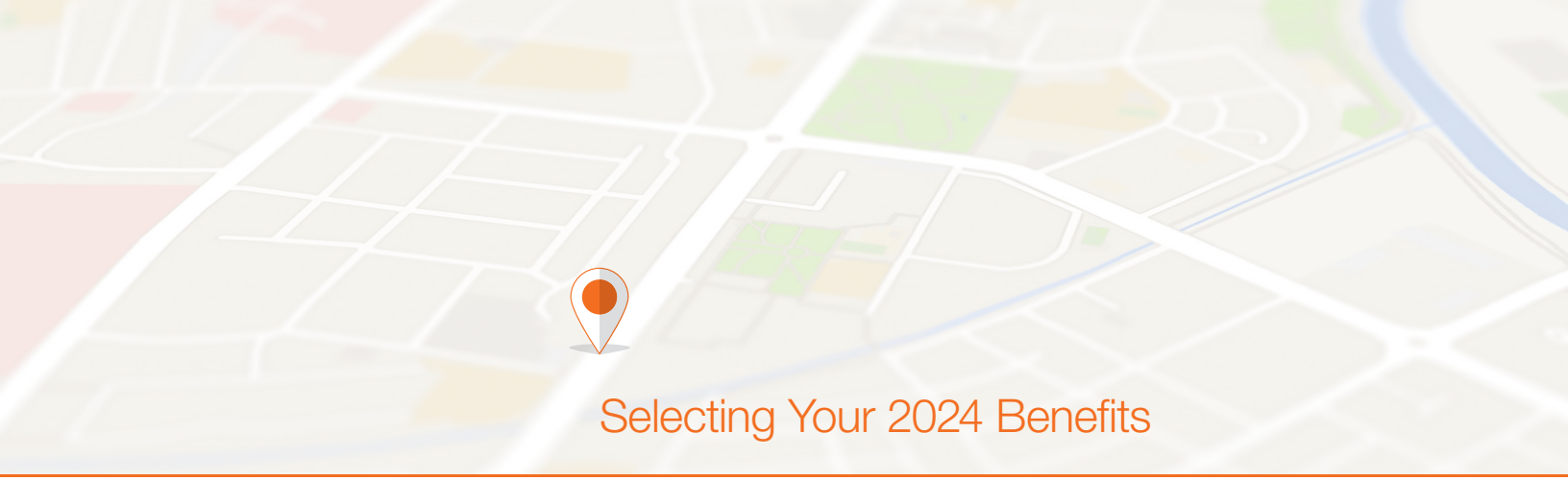
What You Need to Know

- **Annual Enrollment PLUS! New Vendor: Delta Dental. Action Required!** To secure your Medical Trust dental coverage for 2024, you **must** enroll in a Delta Dental PPO + Premier™ (Delta Dental) plan during Annual Enrollment. **Cigna Dental will no longer be offered.**
- Look for a green envelope in the mail this fall. It will contain a letter with important information for Annual Enrollment. Save this letter! It includes the email address and Client Number associated with your MyCPG Account.
- See "How to Enroll" to make your medical and dental plan elections.
- Some plans described in this guide may not be available in all locations or to all groups or diooeses. You will see which plans are available to you when you sign in to *MyCPG Accounts* for Annual Enrollment.
- Coverage tiers, which range from single to family coverage, will depend on what is offered by your group or diooese. Please see your online enrollment form for the coverage tiers available to you. **The rates indicated on your online enrollment form may not necessariily be what your employer requires you to pay.**
- Please see your group administrator if you need to confirm your eligibility for benefits or that of a dependent.
- If you do not make changes or enroll by the deadline, your current medical benefits will continue and any rate changes will apply. **If your current medical plan is not offered in 2024, you must select another plan in order to have medical benefits in 2024.**
- If you are currently enrolled in a Cigna Dental plan and you do not select a plan, you will not have dental coverage through the Medical Trust in 2024.

Since the benefit decisions you make may affect your whole family, please share Annual Enrollment information with other decision-makers in your household.

Glossary of Defined Terms

Please see the Uniform Glossary at *cpg.org/uniform-glossary* for the definitions of the following commonly used terms: *coinsurance, copayment, cost sharing, deductible, emergency medical condition, hospitalization, network, network provider, out-of-network provider, out-of-pocket limit, plan, prescription drugs, and primary care physician*.



Selecting Your 2024 Benefits

Annual Enrollment for 2024 Medical Trust active health benefits begins in October 2023.

Medical Benefits

This is your opportunity to review and make changes to your Medical Trust medical benefits and to add or drop coverage for eligible dependents for the upcoming plan year.

Dental Benefits

You **must** enroll in a Delta Dental PPO + Premier™ plan during Annual Enrollment if you want dental coverage for you and your dependents through the Medical Trust in 2024. **Cigna Dental will no longer be offered.**

Be sure to take the time to review your options by your enrollment deadline. You cannot make changes until the next Annual Enrollment period, unless you have a qualified significant life event (as defined in the Plan Document Handbook), such as the birth of a child, marriage, or divorce.

Changes for 2024

Delta Dental

Effective January 1, 2024, our dental plans are changing—If you are enrolled with Cigna Dental through the Medical Trust, that coverage will not be offered after December 31, 2023. To maintain your dental coverage through the Medical Trust, you must select a Delta Dental plan option for yourself and your dependents during Annual Enrollment for 2024. Learn more in the "Dental Benefits" section.

COVID-19 Provisions

Effective January 1, 2024, member cost sharing (i.e., copayments, deductibles, and coinsurance) will apply based on service type and place of service for healthcare services related to the evaluation and testing for COVID-19.

In addition, effective January 1, 2024, member cost sharing (i.e., copayments, deductibles, and coinsurance) will apply based on service type and place of service for healthcare services relating to the treatment of COVID-19.

COVID-19 Over-the-Counter (OTC) Home Test Kits

- Effective January 1, 2024, eligible individuals and their dependents who are enrolled in Anthem and Cigna PPO medical plans and Kaiser EPO medical plans through the Medical Trust may receive up to four COVID-19 OTC home test kits per month without cost share (i.e., copayment, deductible, and coinsurance).
- Eligible individuals and their dependents who are enrolled in Anthem, Cigna, and Kaiser Consumer-Directed Health Plans (CDHPs) may receive up to four COVID-19 OTC home test kits per month with no coinsurance after they meet their annual network deductible.

Although the Medical Trust is no longer required by law to provide OTC home test kits at no cost, we will still allow members to receive up to four test kits per member per month as described above until further notice.

Telehealth

Telehealth platforms for active members[1]—You can access a medical professional through telehealth platforms offered by Anthem, Cigna, or Kaiser using your computer or mobile device. You will need high-speed internet access, a webcam or built-in camera, and audio capability. Please remember your personal healthcare provider may not participate on the vendor's telehealth platform.

For Anthem, Cigna, and Kaiser members, all services received via vendor telehealth platforms are available to you with no deductible, copayment, or coinsurance through December 31, 2024.

Anthem Blue Cross Blue Shield—Access *LiveHealthOnline.com* or download the LiveHealth Online mobile app in the App Store® or Google Play™.

Cigna—Access *MDLiveforCigna.com* on your computer or download the MDLIVE mobile app by searching in the App Store® or Google Play™.

Kaiser Permanente—Access Kaiser's telehealth platform services by calling the number on the back of your member ID card.

Deductible Increase for Anthem and Cigna CDHP-15

For 2024, the Internal Revenue Service (IRS) increased the minimum and maximum amounts that a high-deductible health plan (HDHP) may impose as a deductible.[2]

For 2024, the minimum amount that must be imposed as a deductible for self-only coverage under an HDHP is $1,600. The minimum amount that must be imposed as a deductible for family coverage under an HDHP is $3,200. The amounts for 2023 were $1,500 and $3,000, respectively.

Effective January 1, 2024, the Medical Trust's Anthem and Cigna CDHP-15 network deductible for self-only coverage will be $1,600, and the network deductible for family coverage will be $3,200. The out-of-network deductible for self-only coverage will be $3,200, and the out-of-network deductible for family coverage will be $6,400.

Deductible Increase for Anthem, Cigna, and Kaiser CDHP-20

The IRS increased the minimum and maximum amounts that an HDHP may impose as a deductible.[2]

For 2024, the minimum amount that must be imposed as a deductible for self-only coverage under an HDHP is $1,600. The minimum amount that must be imposed as a deductible for family coverage under an HDHP is $3,200. The amounts for 2023 were $1,500 and $3,000, respectively.

Effective January 1, 2024, the Medical Trust's Anthem, Cigna, and Kaiser CDHP-20 network deductible for self-only coverage will be $3,200, and the network deductible for family coverage will remain $5,450. The out-of-network deductible for self-only coverage will be $3,200, and the out-of-network deductible for family coverage will remain $6,000.

[1] Please note, telehealth can help with minor, non-life-threatening conditions. During a medical emergency, individuals should visit the nearest hospital or call 911 for assistance.

[2] See *IRS Notice 2023-23*.

Health Plan Options

Medicare Secondary Payer/ Small Employer Exception

Some groups have chosen to participate in the Episcopal Health Plan for Qualified Small Employer Exception (the SEE Plan). See page 5 for information.

All Medical Trust health plans include medical, behavioral, pharmacy, and vision benefits, and provide care through a network of doctors and facilities that have contracted to offer services at reduced rates

You may choose from the following types of health plans, depending on your group or diocese's offerings and the network access in your area:

- Preferred Provider Organization (PPO)
- Consumer-Directed Health Plan (CDHP)/Health Savings Account (HSA)
- Exclusive Provider Organization (EPO) (regional Kaiser plans only)[3]

Preferred Provider Organization (PPO)

You have the flexibility to visit any provider you choose—inside or outside of the plan's network. However, the plan pays greater benefits if you receive care from a network provider or facility.

You are responsible for ensuring that the services and care you receive are covered by your plan. If you use an out-of-network provider, you are often responsible for submitting your own claims and paying the difference between what your provider charges and what the plan covers.

Consumer-Directed Health Plan/ Health Savings Account (CDHP/HSA)

A CDHP is an HSA-qualified plan that works like a PPO. You can receive services from any provider, and you do not have to coordinate your care through a primary care provider (PCP). While the CDHP covers services in and out of the network, it provides strong financial incentives for you to use network providers. Despite the high deductible associated with a CDHP, most preventive care services received from network providers require no member cost share.

About the CDHP

The Kaiser CDHP-20/HSA works like an EPO, with no out-of-network benefits except in emergencies.

You pay the full cost of medical and pharmacy expenses until you meet the annual deductible.

When you enroll in the CDHP, you can contribute tax-free to an HSA, which is a savings account for qualified medical expenses. Your employer may also contribute. Here's how the HSA works:

- You decide if you want to contribute and how much, up to IRS maximums. You can change or stop your contributions any time during the year.
- Use the money in your HSA to pay for qualified medical expenses, including your annual deductible and medical, prescription, dental, and vision costs.
- You may also save the money in your HSA for future medical costs—including qualified medical expenses in retirement.
- Your HSA is portable and will always belong to you, even if you change employers or retire.

[3] Some fully insured plans offered on a regional basis (Hawaii Medical Service Association and Kaiser Permanente Washington) provide an HMO option.

HSA Tax Advantages

There are several tax advantages when you contribute to an HSA:

- You do not pay taxes on your contributions.
- Withdrawals from your HSA are tax-free as long as they are used to pay for qualified medical expenses. Make sure you keep receipts for tax-reporting purposes.
- You may earn tax-free interest, with certain restrictions, or investment earnings.

Exclusive Provider Organization (EPO)—Kaiser

If you enroll in the EPO, you agree to use only Kaiser's network of professionals and facilities. Kaiser does not cover the cost of services received from out-of-network providers, except in emergency situations. You are also responsible for ensuring that the services and care you receive are covered by your plan.

With the Kaiser plans, you are required to select a primary care physician (PCP).

Medicare Secondary Payer/Small Employer Exception (MSP/SEE)

To participate in this program, you must satisfy all of these criteria:

- be age 65 or older,
- actively work for a qualified church or group that offers this choice,
- be enrolled in Medicare Part A (or Medicare Part A and Part B),
- choose a participating Anthem or Cigna plan, and
- be approved for the SEE Plan by Medicare.

If you enroll in the SEE Plan, Medicare will be the primary payer for Part A services. This program is also available for those enrolled in Medicare Part A and Part B. Once Medicare has paid its share, Anthem or Cigna pays claims as it would for any active member, minus the amounts paid by Medicare and you. It is anticipated that out-of-pocket costs will be lower for SEE Plan members and that employers may save on the cost of health benefits.

Eligible members approved by Medicare may enroll in the SEE Plan even if they have dependents who are under the age of 65 and do not have Medicare.

Eligible participants will receive details in the mail.

The SEE Plan is not available for members who enroll in a Kaiser plan.

To Contribute to an HSA

You must be enrolled in the Consumer-Directed Health Plan and cannot

- be covered by Medicare, TRICARE®, or other medical insurance,
- be claimed as a dependent on someone's tax return, or
- be covered by your or your spouse's traditional Flexible Spending Account.

Summary of Benefits and Coverage

For an overview of benefits for each plan, access the *Summary of Benefits and Coverage* documents at *cpg.org/mtdocs*. Paper copies are also available, free of charge, by calling 800-480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

Health Plan Vendors

Go Digital

No matter which plan you choose, you have online tools at your fingertips. Start by registering on your plan's website:

- Anthem: *anthem.com*
- Cigna: *mycigna.com*
- Kaiser: *kp.org*

After you register, download your plan's app to your mobile device from the App Store® or Google Play™ to find network providers and facilities, check claims status, download your Explanation of Benefits (EOB), find cost share information, and much more.

The Medical Trust offers medical plan options through three health plan vendors (not all may be available to you):

- Anthem
- Cigna
- Kaiser

We strive to provide consistent and equitable benefits to all members, regardless of health plan carrier. However, each health plan vendor has differences that may include prior authorization/precertification requirements, medical necessity guidelines, programs and processes, policies and procedures, provider networks, and health plan care management programs.

Following are some of the different programs available by health plan vendors.

See the 2023 Plan Document Handbook for more information about unique programs available from each health plan carrier.

Anthem

Anthem Health Guide—Anthem Health Guides provide you with enhanced member services support. You can contact a health guide with questions about benefits and programs for your health; scheduling physician appointments; comparing costs for procedures, and more. Guides can connect you with knowledgeable health professionals to help you manage chronic conditions, deal with an illness, or provide support for emotional concerns like anxiety or depression. Reach out to Member Services and health guides via phone, email, app, or even chat online.

Virtual Second Opinion Program®—Facing a medical decision? The Virtual Second Opinion Program allows you to access highly specialized providers who can offer educational guidance for certain diagnoses, procedures, or courses of treatment.

Blue Cross Blue Shield Global Core® Program—If you are traveling outside the United States and need medical care, call Anthem's Member Services to find out more about Blue Cross Blue Shield Global Core benefits.

LiveHealth Online® Telehealth—With LiveHealth Online, you have a doctor by your side 24/7. LiveHealth Online lets you talk face-to-face with a provider through your mobile device or a computer with a webcam—no appointments, no driving, and no waiting at an urgent care center.

Cigna

Cigna One Guide®—One Guide combines digital technology with personalized customer service. With One Guide, you have the one-on-one support you need to take control of your health and your health spending. Whether it's choosing a plan, finding a provider, or exploring ways to improve your health, One Guide can help.

You can access a personal guide via app, chat, online, or phone, whenever you need guidance, support, or answers. To get started, just call the number on the back of your Cigna ID Card.

MDLive® Telehealth—MDLive for Cigna telehealth platform enables you to get the care you need—including most prescriptions—for a wide range of minor conditions. You can connect with board-certified providers via secure video chat or phone when, where, and how it works best for you.

Kaiser

Kaiser Telehealth—Phone, interactive video, internet messaging applications, and email between members and their personal Kaiser network providers make it convenient to receive medically appropriate covered services.

Important: Deductibles and Out-of-Pocket Limits

Deductibles—You pay the full cost of healthcare until you reach the plan's annual deductible. Then the plan begins to pay benefits. If you cover family members, please note this:

- The Anthem Consumer-Directed Health Plan-15 (CDHP-15) and the Cigna CDHP-15 require that the family deductible first be met before the plan begins to pay benefits.
- With all other plans, once a member meets the individual deductible, the plan will begin to pay for that member. When the family deductible has been met, the plan will pay for all enrolled family members.

Out-of-Pocket Limits—You plan's annual deductible. Then the plan begins to pay benefits. If you cover family members, please note this:

- The Anthem and Cigna CDHP-15 plans require that the family out-of-pocket limit be met before the plan begins to pay benefits.
- With all other plans, once a member meets the individual out-of-pocket limit, the plan will cover the full cost of eligible expenses for that member for the remainder of the calendar year. When the family out-of-pocket limit has been met, the plan will cover eligible costs for all enrolled family members.

Prescription Drug Benefits

Express Scripts Prescription Drug Program®

When you enroll in one of our **Anthem** or **Cigna** health plans, you will automatically have prescription drug coverage through the Express Scripts Prescription Drug Program.

Express Scripts prescription benefits are available in both retail pharmacies and via home delivery for ongoing, refillable prescriptions. You can realize savings in the following ways:

- by requesting generic drugs whenever possible—Your doctor can advise you on whether a generic medication is appropriate
- by using home delivery for prescriptions you need on an ongoing basis
- by enrolling in the SaveOnSP Copay Assistance Program for certain specialty medications.[4]

Home Delivery—You can order up to 90 days of medication at one time, usually at a significant cost savings, through Express Scripts' home delivery service. The benefits of home delivery include automatic refills and reminders when your prescription is expiring. Use of home delivery is required for maintenance medications after the third refill at a retail pharmacy.

Visit *express-scripts.com* to price a medication, download the formulary, or find a participating retail pharmacy.

For more information, call Express Scripts Member Service at 800-841-3361.

Kaiser Prescription Drug Program

Members enrolled in a **Kaiser** plan receive prescription drug coverage through Kaiser. Call the number on the back of your Kaiser Member ID card for Kaiser pharmacy benefit questions.

[4] The list of specialty pharmacy medications included in the program can be found at *SaveonSP.com/cpg*. Learn more about SaveOnSP in the *Plan Document Handbook*.

Other Plan Benefits[5]

Vision Benefits

If you enroll in an Anthem, Cigna, or Kaiser plan offered through the Medical Trust, you will receive vision benefits through EyeMed Vision Care's Insight Network®.

Vision care benefits include an annual eye exam with no copay when you use a network provider and prescription eyewear or contact lenses offered through a broad-based network of ophthalmologists, optometrists, and opticians at retail chains and independent provider locations. Certain calendar year benefit limitations apply. See the *Plan Document Handbook* for more information.

If you are already registered on the EyeMed site, visit *eyemedvisioncare.com/ecmt* and use your EyeMed member account credentials to log in for details. Click "Need to register?" to create an EyeMed member account.

Employee Assistance Program (EAP)

To help address your emotional, physical, family, and legal needs, the Medical Trust offers the Employee Assistance Program (EAP) managed by Cigna Behavioral Health. If you are enrolled in a Medical Trust health plan, the Cigna EAP is available to you and your household members at no cost to you. Your household members do not need to be enrolled in your health plan to use the Cigna EAP.

This benefit provides immediate help, referrals, and resources. The plan covers telephone consultations and up to 10 face-to-face counseling sessions per issue at no member cost. Cigna EAP services are confidential and available 24/7.

The Cigna EAP staff can provide the following services:

- 24/7 phone access for behavioral health issues
- referrals for in-person counseling
- legal consultations
- financial services and referrals
- tips for balancing work and family
- assistance finding childcare, senior care, and pet care

There are also online resources for topics such as these:

- emotional well-being and life events
- family and caregiving
- health and wellness
- daily living
- disaster resource center

[5] These other plan benefits may not be available to members participating in fully insured plan options offered on a regional basis (Hawaii Medical Service Association and Kaiser Permanente Washington).

The Cigna EAP includes access to **Talkspace® virtual behavioral health**.

- Connect with a licensed therapist or psychiatrist online, by video, or by text using Talkspace, available for Cigna EAP members, ages 13 and up.
- Visit *mycigna.com* to access Talkspace virtual behavioral health.

To access the Cigna EAP, visit *mycigna.com* or call 866-395-7794.

Health Advocate®

This program is like having your own healthcare navigator at no cost to you!

Health Advocate offers help when you have questions about your medical care, from finding a doctor and scheduling an appointment to understanding treatment options for a medical condition to understanding your benefits or resolving a claim.

This service can help you navigate the healthcare system and make the most of your benefits. It is available for you, your dependents, your parents, and your parents-in-law (even if they do not live with you).

Call as often as you need and speak toll-free with a health advocate about your healthcare options. Your information is confidential. Your employer does not receive and does not have access to any of your confidential information. You will be asked to complete and submit forms to protect your privacy.

To access Health Advocate, visit *healthadvocate.com/ecmt* or call 866-695-8622, Monday to Friday, 8:00 AM to 7:00 PM ET.

Dental Benefits

New Vendor: Delta Dental! Action Required!—Delta Dental has the largest network of dentists nationwide and will be our new dental vendor for 2024! If you are currently enrolled in a Cigna Dental plan through the Medical Trust, that coverage is going away. **You must select a Delta Dental PPO + Premier™ (Delta Dental) plan option during Annual Enrollment**, or you will not have dental coverage through the Medical Trust in 2024.

How Delta Dental Can Work for You—You'll be able to access services in two dentist networks (Delta Dental PPO™ and Delta Dental Premier®) or use out-of-network dentists. Your coinsurance, deductible, and maximum annual benefit will vary based on the network you use for a covered dental service. That puts you in charge of making your money go further.

- Providers in the Delta Dental PPO[6] network and Delta Dental Premier network have agreed to contracted rates, and you won't be charged more than your expected share of the bill.[7] **Using the Delta Dental PPO network[8] offers the highest annual maximum benefit, allowing you the most savings.** Using an out-of-network dentist may result in higher out-of-pocket expenses.
- All Delta Dental plan options cover
  - diagnostic care and preventive care
  - three dental cleanings a year (four cleanings based on certain conditions)
  - basic and major restorative services, subject to applicable coinsurance, deductibles, limitations, and exclusions.

[6] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[7] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums, and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[8] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

- Orthodontia services have an enhanced in-network lifetime benefit in the Premium Plan and are also offered in our Comprehensive Plan.

Learn more about what Delta Dental offers you at *cpg.org/deltadental* or call Delta Dental at 888-894-7059.

- You can find a dental provider, check your benefits, and access other helpful resources all in one place at *deltadentalins.com*.
- If you have questions about transition of care, call Delta Dental at 888-894-7059.

See the dental *Summaries of Benefits and Coverage* at *cpg.org/mtdocs* for information on cost sharing for common services.

Travel Assistance Services

When you enroll in a Medical Trust health plan, you have access to UnitedHealthcare Global Assistance®. This travel assistance program can help you with travel needs you encounter while you are outside the United States or 100 or more miles away from home.

The program includes these features:

- assistance in making arrangements to obtain medical treatment, such as a local referral for treatment or evacuation due to a medical emergency
- assistance with providing insurance information and medical records for treatment
- assistance with replacement of prescriptions, medical devices, and corrective lenses
- sassistance procuring emergency travel arrangements and replacement of lost or stolen travel documents
- emergency fund transfers
- destination profiles, which include health and security risks for over 170 countries

IMPORTANT NOTE: UnitedHealthcare Global Assistance is **not** responsible for your medical costs while you are traveling. **If you incur costs, and depending on where you travel, you may be required to pay for your healthcare services.**

If you have an emergency medical event while traveling, contact your travel insurance carrier, if any, and your health plan carrier using the number on your member ID card.

For more information about UnitedHealthcare Global Assistance services, please visit *worldwatch.uhcglobal.com* or call 800-527-0218.

Choosing the Right Plan

Medical

To Help You Make an Informed Choice

The Medical Trust provides *Summaries of Benefits and Coverage* (SBC), which offer important details about a plan's benefits in a standard format to help you compare options.

SBCs are available at *cpg.org/mtdocs*. For a free paper copy, call 800-480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

We know that medical benefits are important to you and your family. There are several important considerations to help you choose the best health plan for you and your family and manage your costs when you need care:

- **Changes to healthcare usage in the upcoming year**—Though it may be tempting to default to the same medical option year after year, healthcare needs change over time. During Annual Enrollment, consider how your healthcare needs might be different in the upcoming year. For example, are you expecting to have a baby or planning to have a medical procedure? As your needs change, the best plan for you may change as well. A good start is to review the current year's Explanations of Benefits (EOB) to see how much you used your benefits and consider how that might change for next year.
- **Pay now or pay later**—It might help to think of the plan options in terms of "pay now" or "pay later." For example, your monthly contributions will be higher in plans with lower out-of-pocket costs, while your monthly contributions will be lower in plans that have higher cost shares. You should consider whether you prefer to pay higher monthly contributions for your coverage and less when you receive services, or to pay less each month with the prospect of paying more when you need services.
- **Network providers**—Your cost for healthcare will be higher if you use a doctor who is not in your plan's network. If you enroll in a Kaiser health plan, you pay the full cost of any non-emergency services provided by a doctor or facility that is not in the plan's network. Contact your health plan or visit its website to check if your provider is in the plan's network.>

Telehealth—Telehealth allows you to connect with a board-certified provider for a wide variety of non-emergency conditions, and even get certain prescriptions from the safety and convenience of your own home. No appointment is necessary.

Plan Going Away

If your current medical plan is not offered in 2024, you must choose a new plan in order to have medical coverage. Also, be sure to verify and make any necessary corrections to your personal and dependent information, especially names, Social Security numbers, and addresses.

If you need help with your medical plan selections, contact a Health Advocate representative for assistance with choosing the best medical plans for you at 866-695-8622 or *answers@HealthAdvocate.com*.

Dental

Your employer may offer dental coverage through the Medical Trust. Dental coverage for 2024 requires active enrollment. That means you must select a dental plan or you will not have coverage. Cigna Dental will no longer be offered after December 31, 2023.

Learn more about Delta Dental plans at *cpg.org/deltadental*, or call Delta Dental at 888-894-7059 to discuss your options.

How to Enroll

Before you go online to enroll, you should be sure to review your personal information, know your plan selections, and have information for any dependents you are adding.

Have the email address associated with your MyCPG Account and your Client Number handy. They were included in the letter that was mailed to your home in a green envelope.

Extension of Benefits

If a dependent will turn age 30 in 2023, they can no longer be covered as dependents under a Medical Trust plan, unless they were disabled prior to age 25, as determined by the Medical Trust. However, the Medical Trust will allow dependent children who turn age 30 in 2023 to voluntarily continue medical and/or dental coverage on their own for up to 36 months commencing on January 1, 2024, through the Medical Trust's Extension of Benefits provision.

Making Your Plan Selections

When you are ready to enroll, go to *cpg.org/annualenrollment* and look for the link to enroll in your plan selections.

Step 1
Sign in to MyCPG Accounts using the email address included in the letter that was mailed to your home in a green envelope.

- You may need to update your password to meet new security standards.
- If you did not see an email address in the letter or if you did not access your account in 2022 or later, please select "Create Account" and follow the prompts.
  - Use your Client Number, which was included in the letter that was mailed to your home in a green envelope. The number can make it easier to verify you during the account setup process.

Step 2
Click on "Annual Enrollment" or go to the "Resources" tab and click the "Annual Enrollment Resources" quick action button to make your elections for 2024.

REMINDER: To maintain your dental coverage through the Medical Trust in 2024, you must select a Delta Dental plan option for yourself and your eligible dependents.

Step 3
Review your information to make sure it is correct.

Please review your personal information, dependent information, and plan elections carefully before completing enrollment.

Step 4
After you make your selections, you can print a confirmation statement for your records.

Please check your selections carefully before you complete the enrollment process.

Your new plan choice takes effect on January 1, 2024. You may receive new ID cards (if applicable) at this time. The Medical Trust can also print many ID cards, or you can print them from the vendor's website. Call CPG's Client Services for assistance at 800-480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET, or email *mtcustserv@cpg.org*.

If You Do Not Enroll by the Deadline

If you miss the deadline and your current plan is still available for 2024, you will continue in the same plan with the same coverage tier as long as you continue to meet the plan's eligibility rules, and any rate changes will apply.

If you do not enroll by the deadline and your current plan is not offered in 2024, your medical and/or dental benefits will end on December 31, 2023, and you cannot re-enroll until the next Annual Enrollment period unless you have a qualified Significant Life Event (as defined in the Plan Document Handbook).

To Learn More

For more information about the health plan(s) available to you, visit our vendors' websites:

Anthem
anthem.com

Cigna Medical
mycigna.com

Cigna Behavioral Health (Employee Assistance Program)
mycigna.com

Delta Dental
deltadentalins.com

Kaiser
kp.org

Express Scripts
express-scripts.com

EyeMed
eyemedvisioncare.com/ecmt

Health Advocate
members.healthadvocate.com

UnitedHealthcare Global Assistance
worldwatch.uhcglobal.com

About The Episcopal Church Medical Trust

The Episcopal Church Medical Trust (Medical Trust) maintains a series of benefit Plans (each a Plan and collectively, the Plans) for the eligible employees (and their eligible dependents) of the Protestant Episcopal Church in the United States of America (hereinafter, The Episcopal Church). Since 1978, the Plans sponsored by the Medical Trust have served the dioceses, parishes, schools, missionary districts, seminaries, and other institutions subject to the authority of The Episcopal Church. The Medical Trust serves thousands of active employees, retirees, and their eligible dependents. The Plans are intended to qualify as "church plans" within the meaning of Section 414(e) of the Internal Revenue Code, and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The Medical Trust funds certain of its benefit Plans through a trust fund known as The Episcopal Church Clergy and Employees' Benefit Trust (ECCEBT).[9] The ECCEBT is intended to qualify as a Voluntary Employees' Beneficiary Association (VEBA) under Section 501(c)(9) of the Internal Revenue Code. The purpose of the ECCEBT is to provide benefits to eligible employees, former employees, and their dependents in the event of illness or expenses for various types of medical care and treatment.

The mission of the Medical Trust is to "balance compassion and benefits with financial stewardship." This is a unique mission in the world of healthcare benefits, and we believe that our experience and mission to serve The Episcopal Church offers a level of expertise that is unparalleled. If you have questions about any of our Plans, please don't hesitate to contact us. We're looking forward to serving you.

For more information about your Medical Trust benefits, please visit *cpg.org* or call Client Services at 800-480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

Eligibility

This *Annual Enrollment Guide* does not contain information on eligibility for plan participation. Should you need confirmation of your eligibility or related details, please see your group administrator.

[9] Church Pension Group Services Corporation is the sponsor of the benefit plans and is doing business under the name "The Episcopal Church Medical Trust."

EPISCOPAL CHURCH
MEDICAL TRUST

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